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PSYCHODYNAMIC PSYCHOTHERAPY FOR PSYCHONEUROSIS: A QUALITATIVE META-SYNTHESIS OF PATIENT OUTCOMES AND EXPERIENCES

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ABSTRACT

The concept of the psychoneuroses represents a pivotal development in the history of psychiatry and psychoanalysis, marking the transition from somatic to psychological understandings of mental distress. This paper provides a comprehensive qualitative examination of the psychoneuroses, tracing their historical emergence, theoretical foundations, clinical manifestations, and contemporary relevance. Drawing upon historical texts, psychoanalytic literature, and recent qualitative research, the paper argues that despite the diagnostic revolution initiated by DSM-III, the psychoneurotic construct retains significant value for understanding the intricate relationship between unconscious conflict, lived experience, and symptomatic expression. Through detailed analysis of major psychoneurotic subtypes, including hysteria, anxiety states, obsessive-compulsive neurosis, neurasthenia, and hypochondriasis, this paper illuminates the enduring clinical and theoretical significance of the concept. The qualitative approach adopted here prioritizes subjective experience, narrative coherence, and meaning-making processes, offering insights that complement and extend contemporary biopsychosocial frameworks. The paper concludes by considering the implications of psychoneurotic theory for current psychiatric practice and research, particularly regarding the integration of psychodynamic understanding with evidence-based treatment approaches.

1. INTRODUCTION

The term "psychoneurosis" occupies a singular and contested position in the history of psychiatric thought. Coined in the late nineteenth century to distinguish psychological disturbances from organic nervous disorders, the concept represented a fundamental reconceptualization of mental illness that continues to reverberate through contemporary clinical practice and theory (May-Tolzmann, 1998). At its core, the psychoneurosis concept asserts that certain forms of psychological suffering, manifesting in anxiety, compulsive behaviors, conversion symptoms, and profound emotional distress, originate not in neurological pathology but in the complex workings of the human mind, shaped by experience, conflict, and meaning-making processes (Berne, 2021).

The Austrian psychiatrist Sigmund Freud (1856-1939): drawing upon his clinical observations and his collaboration with Josef Breuer, was instrumental in developing and popularizing the concept of psychoneurosis (de Mijolla, 2018). His formulation challenged the prevailing medical orthodoxy that neurotic symptoms had localized organic origins, proposing instead that they were expressions of unconscious emotional conflicts rooted in early experience. This paradigm shift opened new possibilities for understanding and treating mental disorders, establishing the foundation for psychoanalysis and profoundly influencing subsequent psychotherapeutic approaches (May-Tolzmann, 1998).

However, the trajectory of the psychoneurosis concept has not been linear. The publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 marked a decisive break with psychoanalytic psychiatry, replacing dynamic formulations with descriptive, criterion-based diagnoses (Brauser, 2015). This "neo-Kraepelinian" revolution, as it came to be known, sought to align psychiatry with the

medical model by emphasizing observable symptoms, reliability, and biological underpinnings (Frances & Widiger, 2012). The psychoneuroses, as a unified diagnostic category, were effectively dismantled, their constituent conditions redistributed across various anxiety, somatoform, and dissociative disorders.

Yet the conceptual and clinical utility of the psychoneurotic framework has not disappeared. Recent qualitative research has demonstrated the persistent relevance of understanding mental disorders through the lens of lived experience, narrative coherence, and relational context (Hájková, 2007). Studies examining the subjective experience of functional neurological disorders, for example, have identified themes of "relationally regulated selves" and the profound impact of stress, trauma, and interpersonal conflict on symptom formation (Qualitative systematic review, 2025). These findings echo fundamental psychoneurotic principles, suggesting that the construct merits renewed attention.

This paper offers a qualitative exploration of the psychoneuroses, examining their historical development, theoretical foundations, clinical manifestations, and contemporary significance. Adopting a qualitative approach, prioritizing narrative, meaning-making, and subjective experience over quantitative measurement, the paper aims to illuminate aspects of the psychoneurotic experience that may be obscured by purely descriptive diagnostic frameworks. The analysis draws upon historical texts, psychoanalytic literature, qualitative research studies, and clinical case material to construct a rich and nuanced account of the psychoneuroses and their enduring relevance.

The paper proceeds as follows. Section 2 traces the historical origins and development of the psychoneurosis concept, from its nineteenth-century emergence to its transformation in the era of descriptive psychiatry. Section 3 examines the theoretical foundations of psychoneurotic understanding, particularly the contributions of Freud and subsequent psychoanalytic thinkers. Section 4 provides detailed qualitative analysis of major psychoneurotic subtypes, exploring their phenomenology, aetiology, and treatment implications. Section 5 considers the contemporary relevance of the psychoneurosis concept in light of recent qualitative research and clinical developments. Section 6 addresses treatment and therapeutic approaches, while Section 7 considers the future of psychoneurotic theory. The paper concludes by reflecting on the value of the psychoneurotic framework for understanding the complex, meaning-laden nature of human psychological suffering.

2. Historical Origins and Development

2.1 The Emergence of the Neurosis Concept

Understanding the psychoneuroses requires situating them within the broader history of the neurosis concept. The term "neurosis" emerged in the eighteenth century as a designation for nervous disorders that, while producing significant functional impairment, were believed to have no identifiable organic lesion (McWilliams, 2011). As Albert Eulenburg noted in his Real-Encyklopädie der gesammten Heilkunde, neuroses were understood as conditions "which do not at present admit of a pathological-anatomical definition and localization" (quoted in May-Tolzmann, 1998, p. 368). This definition, while acknowledging the limitations of contemporary medical knowledge, implicitly assumed an organic basis awaiting discovery.

Throughout the nineteenth century, the neurosis concept underwent considerable elaboration and differentiation. Various forms of "nervous disease" were distinguished, including hysteria, hypochondriasis, and neurasthenia, each understood as involving disturbances of the nervous system. The term "psychoneurosis" emerged during this period as a way of characterizing those neurotic conditions that appeared primarily psychological in nature, though the precise boundaries remained contested (Berrios, 1996). Some authorities, such as Richard von Krafft-Ebing, distinguished psychoneuroses as "psychic disturbances which affect individuals with sound brains" (quoted in May-Tolzmann, 1998, p. 369): preserving the distinction between functional and organic pathology.

The conceptual evolution of neurosis reflected broader intellectual currents of the nineteenth century, including the rise of neurology as a distinct medical specialty and the growing recognition of the importance of psychological factors in illness (Shorter, 1992). The work of Jean-Martin Charcot at the Salpêtrière in Paris demonstrated that hysterical symptoms could be induced and relieved through suggestion, suggesting a psychological dimension to what had been considered neurological disorders (Ellenberger, 1970). These developments set the stage for the revolutionary contributions of Freud.

2.2 Freud's Contribution: The Psychological Turn

The transformation of the psychoneurosis concept into a fundamentally psychological construct is attributable primarily to the work of Sigmund Freud. His collaboration with Josef Breuer in the 1890s, particularly their work on the case of "Anna O.," convinced Freud that hysterical symptoms were not organic in origin but expressed psychological content that had been rendered unconscious through a process of defence (Breuer & Freud, 1895/1955). The concept of "psychoneurosis of defence" emerged from this work, designating conditions in which symptoms served to protect the psyche from unbearable emotional conflict (Freud, 1894/1962).

Freud's theoretical development proceeded through several stages. Initially, he emphasized the role of actual sexual experience in the aetiology of neuroses, proposing

that childhood sexual abuse was the universal cause of hysteria (Freud, 1896/1962). However, he subsequently revised this "seduction theory," recognizing that the traumatic experiences reported by patients might not always be literally true but rather represented unconscious fantasies (Masson, 1984). This shift directed attention toward the inner world of psychic reality, the realm of wishes, fears, and conflicts, as the primary source of neurotic suffering (Freud, 1900/1953).

Freud distinguished between "actual neuroses" and "psychoneuroses," a distinction that remained central to his thinking. Actual neuroses, including neurasthenia and anxiety neurosis, were understood as direct physiological consequences of sexual dysfunction, such as abstinence or excessive masturbation (Freud, 1895/1962). Psychoneuroses, in contrast, were products of psychological conflict, involving the operation of defence mechanisms that transformed unacceptable impulses into symptomatic expressions (Freud, 1915/1957). This distinction, while theoretically significant, proved difficult to maintain in clinical practice, as actual neurotic symptoms were often embedded in broader psychoneurotic constellations.

The development of psychoanalytic technique accompanied and informed Freud's theoretical elaboration. The method of free association, the analysis of dreams, and the interpretation of transference provided tools for accessing the unconscious conflicts that Freud believed underlay psychoneurotic symptomatology (Freud, 1912/1958). These techniques established a new form of therapeutic engagement, one that privileged the patient's subjective experience and the unfolding of the therapeutic relationship over the authority of the physician.

2.3 The Nosological Revolution: From Classification to Description

The mid-twentieth century witnessed a profound transformation in psychiatric nosology that fundamentally altered the status of the psychoneurosis concept. In 1948, the American Psychiatric Association undertook to develop a standardized diagnostic system, a process that culminated in the publication of DSM-I in 1952 (Brauser, 2015). While this early edition retained significant psychoanalytic influence, including the category of "psychoneurotic disorders," subsequent revisions progressively marginalized dynamic formulations.

The publication of DSM-III in 1980 represented a decisive turning point. Led by Robert Spitzer and guided by the principles of operational diagnosis, DSM-III abandoned psychoanalytic concepts in favor of descriptive, criterion-based definitions (Frances & Widiger, 2012). The psychoneuroses, as a unified diagnostic category, were eliminated, their constituent conditions redistributed across various diagnostic classes. This shift reflected broader changes in American psychiatry, including the rise of psychopharmacology and the desire to align the discipline with the medical mainstream (Wilson, 1993).

The elimination of the psychoneurosis category had profound consequences. It facilitated the development of reliable diagnostic instruments and enhanced communication among researchers, but it also contributed to what some observers have termed a "furor diagnosticus", a proliferation of diagnostic labels that risk trivializing the human condition by denying "its inescapable, somber, and even tragic elements" (Chodoff, 2002, p. 349). Critics have argued that the neo-Kraepelinian approach, while methodologically rigorous, has lost something essential: the recognition that psychological symptoms are not simply observable entities but expressions of individual life history, meaning-making, and subjective experience (McWilliams, 2011).

The international classification systems have followed a parallel trajectory. The International Classification of Diseases (ICD) has moved toward descriptive criteria, though it has retained some features of the psychodynamic tradition to a greater extent than the DSM (World Health Organization, 1992). The ICD-10 includes categories such as "neurotic, stress-related and somatoform disorders," preserving a conceptual link to the neurosis tradition while adopting descriptive criteria for individual conditions.

2.4 The Influence of American Psychoanalysis

The development of psychoneurotic theory in the United States followed a somewhat different trajectory than in Europe. American psychoanalysis, particularly through the work of the so-called "ego psychologists," emphasized the adaptive functions of the ego and the importance of autonomy and mastery in psychological development (Hartmann, 1939/1958). This emphasis shifted the focus from instinctual conflict to the individual's capacity for reality testing, impulse control, and object relations.

The rise of ego psychology contributed to a more optimistic view of the treatability of psychoneurotic conditions. If the ego could be strengthened through therapeutic intervention, patients could be helped to manage conflict more effectively and to develop more adaptive defences (Brenner, 1976). This perspective influenced the development of brief psychodynamic therapies, which offered more accessible and cost-effective alternatives to classical psychoanalysis (Malan, 1976).

The influence of American psychoanalysis on psychiatric practice was considerable throughout the mid-twentieth century. Many psychiatrists were trained in psychoanalytic institutes, and psychodynamic formulations were widely used in clinical practice (Wilson, 1993). However, the dominance of

psychoanalytic psychiatry was not without its critics, who argued that psychoanalytic theories were unscientific, unverifiable, and of limited therapeutic effectiveness. These criticisms contributed to the decline of psychoanalytic influence and the rise of alternative approaches.

3. Theoretical Foundations of the Psychoneuroses

3.1 The Psychoanalytic Framework

The psychoneurosis concept is inextricably linked to psychoanalytic theory, which provides its primary explanatory framework. At the heart of the psychoanalytic understanding of psychoneurosis is the proposition that symptoms are not arbitrary or meaningless but are expressive of unconscious mental content (Freud, 1917/1963). This content, comprising wishes, fears, memories, and conflicts, has been rendered unconscious through processes of psychological defence because it is unacceptable to the conscious mind.

Freud's structural model of the psyche, comprising the id, ego, and superego, provides a systematic framework for understanding psychoneurotic conflict. The id, representing primitive instinctual drives, presses for immediate gratification. The superego, embodying internalized moral standards and ideals, opposes these drives with prohibitions and guilt. The ego, caught between these conflicting forces and the demands of external reality, must negotiate a compromise (Freud, 1923/1961). When this compromise fails or is insufficient, anxiety arises, triggering defensive operations that may result in symptomatic expression.

The concept of defence mechanisms is central to understanding how psychoneurotic symptoms are formed. Repression, the foundational defence, involves the active exclusion of unacceptable thoughts and feelings from consciousness (Freud, 1915/1957). Other defences, such as reaction formation, projection, and displacement, operate to transform or redirect threatening impulses into more acceptable forms. The particular constellation of defences mobilized, combined with the nature of the underlying conflict and the individual's constitutional temperament, shapes the specific form that psychoneurotic symptomatology takes.

The psychoanalytic theory of anxiety has evolved significantly over time. Freud initially distinguished between realistic anxiety (fear of external danger) and neurotic anxiety (fear of internal impulses). He later revised his theory to propose that anxiety is the signal of danger that triggers defensive operations (Freud, 1926/1959). This signal theory of anxiety has been influential in understanding how psychoneurotic symptoms develop and are maintained.

3.2 Transference and the Therapeutic Relationship

A distinctive feature of the psychoanalytic approach to psychoneurosis is its emphasis on transference, the phenomenon by which patients unconsciously project feelings, attitudes, and expectations derived from early relationships onto the therapist (Freud, 1912/1958). Freud observed that patients with hysterical, phobic, and obsessive-compulsive symptoms were capable of forming such emotional ties, which he designated "transference neuroses" to distinguish them from the narcissistic neuroses (psychoses and severe depression) in which such transference formation was thought to be impossible (Freud, 1917/1963).

The concept of transference has profound implications for understanding psychoneurotic experience and treatment. It suggests that current relationships, including the therapeutic relationship, are inevitably colored by past experience, and that unconscious patterns of relating may be enacted rather than simply described. The analysis of transference, therefore, becomes a primary avenue for understanding the patient's internal world and for effecting therapeutic change (Luborsky & Crits-Christoph, 1998).

Contemporary psychoanalytic thinkers have expanded the concept of transference to include the therapist's contributions as well. The concept of countertransference, the therapist's emotional responses to the patient, has been recognized as a valuable source of information about the patient's internal world and the dynamics of the therapeutic relationship (Heimann, 1950). This intersubjective turn in psychoanalysis has enriched understanding of the therapeutic process and has implications for the treatment of psychoneurotic conditions.

3.3 Early Experience and the Origins of Conflict

Psychoanalytic theory places considerable emphasis on early experience as a determinant of psychoneurotic vulnerability. The developing child, faced with immature intellectual, emotional, and imaginative capacities, must navigate relationships with primary caretakers while managing inner fears and impulses (Fraiberg, 1959). Frustration and conflict inevitably emerge, and patterns of emotional experience, fantasy, and behavior develop in response to these challenges.

The psychoanalytic developmental framework suggests that certain experiences are particularly significant in shaping psychoneurotic vulnerability. Unresolved Oedipal conflicts, involving triangular dynamics of love, jealousy, and rivalry, are thought to be central to the formation of neurotic symptomatology (Freud, 1924/1961). Similarly, pre-Oedipal experiences of separation, loss, and ambivalence may contribute to the development of depressive and anxious tendencies (Klein, 1946).

Modern psychoanalytic thinkers, while retaining the emphasis on early experience, have broadened the focus to include attachment relationships, trauma, and the influence of later developmental phases (Eagle, 2011).

The work of John Bowlby and Mary Ainsworth on attachment theory has been particularly influential, highlighting the importance of early caregiving relationships in shaping emotional development and vulnerability to psychopathology (Bowlby, 1969). Research on attachment has demonstrated that insecure attachment patterns, including anxious and avoidant styles, are associated with increased vulnerability to anxiety and mood disorders (Mikulincer & Shaver, 2007).

3.4 Qualitative Perspectives on Psychoneurotic Experience

Recent qualitative research has enriched understanding of psychoneurotic experience by foregrounding the subjective perspective of sufferers. Narrative approaches, for example, have demonstrated that individuals with neurotic disorders often construct life stories characterized by certain patterns: limited differentiation of experience, difficulties in making coherent meaning of events, and restricted openness to alternative interpretations (Hájková, 2007). These narrative patterns are not merely epiphenomena but may themselves contribute to the maintenance and perpetuation of symptomatology.

Qualitative research on functional neurological disorders, a condition historically associated with psychoneurotic formulations, has identified themes of "relationally regulated selves" and the profound impact of interpersonal stress on symptom formation (Qualitative systematic review, 2025). Patients often report feeling "not believed in" or shamed by healthcare professionals, experiences that compound their suffering and complicate treatment engagement (Qualitative systematic review, 2025). These findings underscore the importance of attending to the relational context of psychoneurotic experience, a dimension that is often overlooked in purely descriptive diagnostic approaches.

The lived experience of individuals with obsessive-compulsive disorder and anxiety has also been explored through qualitative methods. One autobiographical study traced the evolution of neurotic symptomatology through adolescence and young adulthood, illuminating the ways in which attempts to manage anxiety can paradoxically generate new forms of suffering (Westoby, 2019). The narrative reveals how recovery, when understood as the achievement of control over internal experience, may itself become a new source of neurotic preoccupation, a phenomenon that resonates with psychoanalytic concepts of symptom substitution and defence.

4. Major Psychoneurotic Subtypes: A Qualitative Analysis

4.1 Hysteria

Hysteria represents the prototypical psychoneurosis in the Freudian framework, the condition through which the fundamental principles of psychoanalysis were initially established. As historically understood, hysteria involves the emergence of physical symptoms, such as paralysis, anaesthesia, or convulsions, that have no apparent organic basis and that serve an unconscious psychological function (Breuer & Freud, 1895/1955). The symptoms are often dramatic in character, providing the patient with an unconscious escape from a painful situation or an unmanageable conflict (Freud, 1909/1955).

The psychodynamic understanding of hysteria emphasizes the role of conversion, the transformation of psychological conflict into somatic symptomatology. The symptom, in this view, represents a symbolic expression of the underlying conflict, rendering it in a form that is simultaneously recognizable and disguised (Freud, 1917/1963). The "body language" of the hysteric speaks what the conscious mind cannot articulate, converting psychological suffering into physical distress (McWilliams, 2011).

Qualitatively, the hysterical experience is characterized by a particular relationship to bodily experience and symptom formation. The symptoms, while genuinely experienced by the patient, are not accompanied by the typical subjective sense of somatic causation; rather, they seem to arise from elsewhere, as an imposition on the self (Kirmayer et al., 1994). This aetiological ambiguity can lead to significant diagnostic confusion and to experiences of being disbelieved or misunderstood by healthcare professionals, experiences that have been documented in contemporary qualitative research on functional neurological disorders (Qualitative systematic review, 2025).

The concept of hysteria has undergone significant transformation in contemporary diagnostic systems. DSM-5 does not include hysteria as a formal diagnostic category, distributing its manifestations across conversion disorder (functional neurological symptom disorder): dissociative disorders, and somatic symptom disorder (American Psychiatric Association, 2013). This shift reflects both theoretical developments and the recognition that hysterical phenomena are more heterogeneous than previously appreciated. Nevertheless, the hysterical dynamic, the expression of psychological conflict through physical symptomatology, remains clinically relevant, particularly in settings where neurological and psychiatric presentations overlap (Stone et al., 2005).

4.2 Anxiety States

Anxiety states, as originally conceptualized, were characterized by persistent feelings of fear, apprehension, and tension, punctuated by acute panic attacks during which both physical and mental symptoms of extreme fear were manifest (Freud, 1895/1962). Freud distinguished anxiety neurosis from the broader category of psychoneuroses, regarding it as an "actual neurosis"

with a somatic rather than psychological basis, specifically, the accumulation of unpleasurable physical sexual tension (Freud, 1895/1962). However, anxiety symptoms commonly co-occur with other psychoneurotic conditions, suggesting a complex relationship between somatic and psychological factors.

The qualitative experience of anxiety states is characterized by the pervasive sense of dread and foreboding that colors daily life. The anxious individual lives in a state of heightened vigilance, anticipating threat and scanning the environment for danger signals (Beck & Clark, 1997). This chronic vigilance, while cognitively mediated, is also experienced viscerally: in the racing heart, the tight chest, the shallow breath, and the trembling hands that accompany anxious arousal (Barlow, 2002).

Contemporary diagnostic frameworks have transformed anxiety neurosis into a collection of discrete disorders, including generalized anxiety disorder, panic disorder, and social anxiety disorder (American Psychiatric Association, 2013). This fragmentation reflects the influence of descriptive psychiatry, which prioritizes observable symptom patterns over underlying dynamics. However, the qualitative experience of anxious suffering, the subjective sense of being trapped in a state of fear that is both excessive and uncontrollable, remains consistent across these diagnostic categories.

Situation difficulties, such as interpersonal conflicts, professional stress, and life transitions, are often precipitating factors in the onset of anxiety symptoms, particularly in those with predisposing characteristics (Barlow, 2002). This observation aligns with the qualitative finding that "relational conflict in any arena" contributes to the development of functional neurological symptoms, suggesting that the relationship between interpersonal stress and somatopsychic expression is a general principle rather than a disorder-specific phenomenon (Qualitative systematic review, 2025).

4.3 Neurasthenia

Neurasthenia, as classically described, is characterized by extreme physical and mental fatigue, accompanied by numerous and ever-changing bodily complaints (Beard, 1869). The condition may be brought on by physical or mental strain, but there is often also a sexual basis for the disorder in the Freudian formulation (Freud, 1895/1962). The neurasthenic experience is one of exhaustion, of being drained of energy and capacity, unable to sustain the ordinary demands of daily life (Taylor, 2001).

The qualitative character of neurasthenia is captured in the metaphor of the "depleted battery": the neurasthenic individual feels that their resources are exhausted, that they are operating on reserve energy that is rapidly diminishing (Shorter, 1992). This sense of depletion is both physical and psychological, manifesting in fatigue that is not relieved by rest, in difficulty concentrating, in emotional lability, and in a myriad of somatic complaints that shift over time (Abbey & Garfinkel, 1991).

Historically, neurasthenia was understood as a condition of civilization, a consequence of the demands of modern life and the exhaustion of nervous energy (Beard, 1869). This cultural dimension of the diagnosis is significant, suggesting that the expression of psychological distress may be shaped by social and cultural factors. The concept of neurasthenia has been revived in some non-Western settings, where it remains a culturally acceptable way of expressing psychological distress (Kleinman, 1986).

Neurasthenia has disappeared from contemporary diagnostic manuals, its place taken by chronic fatigue syndrome, burnout, and mood disorders (Wessely et al., 1999). While this fragmentation may enhance diagnostic specificity, it risks obscuring the holistic character of neurasthenic suffering, the way in which fatigue, physical symptoms, and emotional distress are interwoven in a single experiential fabric. The qualitative tradition, with its emphasis on subjective coherence, may offer a more faithful representation of neurasthenic experience than the fragmented categories of descriptive psychiatry.

4.4 Obsessive-Compulsive Neurosis (Psychasthenia)

Obsessive-compulsive neurosis, or psychasthenia, is characterized by morbid doubts, fears, feelings of unreality, and irresistible urges to think, feel, or do something that is recognized as irrational (Janet, 1903). The obsessive-compulsive individual is caught in a struggle with their own mind, unable to banish intrusive thoughts or to resist the impulse to perform ritualistic actions (Freud, 1909/1955). This internal conflict, the rational self confronting the irrational compulsion, is central to the phenomenology of obsessive-compulsive suffering (Rachman & Hodgson, 1980).

The qualitative experience of obsessive-compulsive neurosis is one of being trapped in an endless cycle of anxiety and attempted relief (Westoby, 2019). The obsession, an idea, impulse, or image that intrudes into consciousness, generates intense anxiety, which is temporarily relieved by performing a neutralizing action or ritual. However, this relief is short-lived; the obsession returns, and the cycle repeats (Salkovskis, 1985). The obsessive-compulsive individual experiences this pattern as irrational, even absurd, yet finds themselves unable to break free (Veale, 2007).

Obsessive-compulsive neurosis has been particularly associated with certain personality characteristics: sensitivity, meticulousness, self-consciousness, and high intellect (Freud, 1908/1959). The individual with this vulnerability may be exquisitely attuned to their own mental processes, hyperaware of the gap between their idealized self and their actual experience (Shapiro, 1965). This self-consciousness, while perhaps

contributing to intellectual achievement, also creates the conditions for obsessive self-scrutiny and doubt.

Contemporary diagnostic frameworks have largely preserved the concept of obsessive-compulsive disorder (OCD): though the link to a particular personality structure has been loosened (American Psychiatric Association, 2013). The ICD-10 and DSM-5 include OCD as a distinct diagnostic category, emphasizing the presence of obsessions and compulsions as the core features. Recent advances in neuroscience and behavioral treatment have transformed the management of OCD, but the qualitative character of obsessive-compulsive suffering, the internal struggle with unwanted thoughts and impulses, remains recognizably the same as described in the classic literature (Abramowitz et al., 2010).

4.5 Hypochondriasis

Hypochondriasis is a condition in which the individual's entire interest is centered upon the imagined disorders and diseases of their bodily organs (Freud, 1917/1963). The hypochondriacal experience is one of being occupied, even consumed, by concerns about health and disease. Every bodily sensation is scrutinized for signs of pathology; every symptom, no matter how trivial, is interpreted as evidence of serious illness (Barsky & Wyshak, 1990). This preoccupation, while focused on the body, is ultimately psychological in nature, expressing underlying anxieties about mortality, vulnerability, and control (Salkovskis & Warwick, 2001).

The hypochondriacal personality is often described as introverted, turned inward, attuned to the subtle fluctuations of internal experience (Pilowsky, 1978). This inward orientation, while perhaps reflecting a constitutional disposition, is also likely shaped by experience: the hypochondriacal individual may have learned to attend to bodily signals as a way of managing anxiety, seeking reassurance through medical contact, or communicating distress in a socially acceptable form (Kellner, 1986).

The relationship between hypochondriasis and other psychoneurotic conditions is complex. Some authors have viewed hypochondriasis as a variant of anxiety disorder, with health-related fears being the specific focus of anxious concern (Salkovskis & Warwick, 2001). Others have emphasized the depressive features of hypochondriasis, noting that health preoccupations often intensify during periods of low mood (Kellner, 1986). This comorbidity suggests that hypochondriasis is best understood within a broader psychodynamic framework, as an expression of underlying conflict that takes a particular form in a vulnerable individual.

Hypochondriasis has been subsumed within the diagnostic category of illness anxiety disorder in contemporary diagnostic frameworks (American Psychiatric Association, 2013). The shift in terminology reflects a recognition that preoccupation with illness is a form of anxiety rather than a distinct entity. However, the qualitative character of hypochondriacal experience, the sense of being haunted by the threat of illness, the endless quest for reassurance, the frustration of finding no relief, remains consistent, and the condition remains challenging to treat effectively (Barsky & Ahern, 2004).

4.6 The Unity of Psychoneurotic Experience

Despite their diversity, the psychoneurotic subtypes share a common underlying structure. In each case, the symptom expresses a psychological conflict that has been rendered unconscious through defensive operations (Freud, 1917/1963). The specific form of the symptom, whether physical, cognitive, or behavioral, is shaped by the nature of the underlying conflict, the constitutional predispositions of the individual, and the availability of symbolic expression.

The qualitative experience of psychoneurosis across subtypes reveals common themes. Sufferers often describe feeling trapped, unable to change patterns of thought, feeling, or behavior that they recognize as problematic. There is a sense of being divided against oneself, of being subject to forces within that are beyond conscious control (Fenichel, 1945). This experience of internal division, of being at war with oneself, is perhaps the defining qualitative feature of psychoneurotic suffering.

The experience of shame is also prominent in many psychoneurotic conditions. The individual may feel ashamed of their symptoms, perceiving them as signs of weakness or moral failure (Lewis, 1971). This shame may compound the suffering associated with the symptoms themselves, leading to withdrawal from others and a reluctance to seek treatment. The therapeutic relationship, in which the individual can speak openly about their shame without fear of judgment, is therefore essential to effective treatment.

5. Contemporary Relevance and Applications

5.1 Reconsidering Psychoneurosis in the DSM Era

The elimination of the psychoneurosis category from official diagnostic systems does not mean that the concept has lost its value. Indeed, the limitations of purely descriptive approaches have become increasingly apparent, prompting renewed interest in the kinds of understanding that psychodynamic frameworks can provide. Critics have noted that the proliferation of diagnostic categories in successive editions of the DSM has not been matched by commensurate advances in therapeutic effectiveness (Chodoff, 2002). The "furor diagnosticus" identified by Paul Chodoff, the excessive labeling of human suffering, may obscure rather than illuminate the nature of psychological distress.

The psychoneurosis concept offers an alternative to the fragmentation of descriptive psychiatry. By emphasizing

the common dynamic structure underlying diverse symptomatic expressions, it provides a unified framework for understanding the relationship between conflict, defence, and symptom formation (McWilliams, 2011). This framework does not replace descriptive diagnosis but complements it, offering a depth dimension that is often lacking in purely symptomatic approaches.

The rediscovery of the psychoneurosis concept in contemporary clinical practice is evident in several areas. Psychodynamic formulations continue to inform the understanding of treatment resistance, the development of therapeutic relationships, and the management of complex clinical presentations (Gabbard, 2014). The concept of the "neurotic core" remains useful for understanding patients who present with multiple, often changing symptoms that do not fit neatly into diagnostic categories.

5.2 Qualitative Research and Psychoneurotic Experience

Recent qualitative research has demonstrated the value of exploring mental disorders through the lens of lived experience (Hájková, 2007). Studies examining the subjective experience of functional neurological disorder, for example, have identified themes that resonate deeply with the psychoneurotic tradition: the sense of being disbelieved, the importance of relational context, the role of stress and trauma in symptom formation (Qualitative systematic review, 2025). These findings suggest that the psychoanalytic emphasis on meaning and conflict remains clinically relevant, even as diagnostic frameworks have shifted.

The qualitative approach has particular value in understanding the aetiology and maintenance of psychoneurotic symptoms. While quantitative studies can identify statistical associations, qualitative methods can illuminate the processes through which events are experienced, interpreted, and incorporated into the self-narrative (Hájková, 2007). The narrative approach, in particular, has demonstrated that individuals with neurotic disorders often tell stories that lack coherence, differentiation, and openness to change, patterns that may both reflect and perpetuate their difficulties.

Future qualitative research on psychoneurotic experience should attend to the "life stories, relational history, and all significant stress, trauma and loss of sufferers" (Hájková, 2007, p. 12). This biographical perspective, central to the psychodynamic tradition, may offer insights that are not accessible through cross-sectional assessment alone. The life-line method, which invites individuals to narrate their life story as a coherent narrative, has been identified as a particularly promising approach for exploring the integration of life experience in neurotic disorder (Hájková, 2007).

5.3 Integrating Psychodynamic Understanding with Evidence-Based Practice

The contemporary mental health field faces the challenge of integrating psychodynamic understanding with the demands of evidence-based practice. While randomized controlled trials have demonstrated the efficacy of cognitive-behavioral and pharmacological treatments for many conditions historically considered psychoneurotic, these approaches may not fully address the depth and complexity of psychoneurotic suffering (Leichsenring et al., 2015).

Qualitative research on the lived experience of psychoneurotic symptoms has highlighted the importance of the therapeutic relationship in effective treatment (Qualitative systematic review, 2025). Patients often feel "abandoned, not believed in or even shamed by healthcare professionals" (Qualitative systematic review, 2025, p. 15): suggesting that attention to the relational dimension of care is essential. The psychodynamic tradition, with its emphasis on transference and the therapeutic relationship, offers resources for addressing these relational challenges.

Psychoanalytic psychotherapies have evolved considerably since Freud's time, incorporating advances in developmental psychology, attachment theory, and interpersonal neurobiology (Gabbard, 2014). Modern psychoanalytic clinicians are better equipped to work with the full range of psychopathology, including the borderline and psychotic conditions that Freud thought unsuitable for psychoanalytic treatment (Bateman & Fonagy, 2012). The therapeutic approach to psychoneurosis has accordingly become more flexible, integrating psychoanalytic techniques with psychoeducation, cognitive interventions, and, when appropriate, medication.

6. Treatment and Therapeutic Approaches

6.1 Psychotherapeutic Interventions

Psychotherapy remains the cornerstone of treatment for psychoneurotic conditions, consistent with the understanding that these disorders originate in psychological conflict. A range of psychotherapeutic approaches have been developed, including psychoanalysis, psychoanalytic psychotherapy, cognitive-behavioral therapy, and supportive counseling (Gabbard, 2014).

Psychoanalysis, the most intensive and historically significant approach, involves the systematic exploration of unconscious conflict through the analysis of free associations, dreams, and transference. While its applicability to all psychoneurotic conditions is now questioned, it remains a valuable treatment for selected patients, particularly those with long-standing, characterological difficulties (Leichsenring et al., 2015). The benefits of psychoanalysis include the opportunity for deep character change, not merely symptom reduction.

Cognitive-behavioral therapy (CBT) has emerged as the most empirically supported psychotherapeutic treatment for many conditions historically considered psychoneurotic, including anxiety disorders and obsessive-compulsive disorder (Abramowitz et al., 2010). CBT addresses symptoms directly, challenging maladaptive thought patterns and promoting the extinction of conditioned fears. However, some critics have argued that CBT, while effective, does not address the underlying psychological conflicts that predispose to symptom formation, leaving individuals vulnerable to relapse (Shedler, 2010).

6.2 Pharmacological Interventions

Pharmacological treatments play an increasingly important role in the management of psychoneurotic conditions, particularly for symptoms of anxiety and depression. The psychopharmacological revolution that began in the 1950s transformed psychiatric practice, making effective symptom relief available to millions (Healy, 1997). Selective serotonin reuptake inhibitors (SSRIs): benzodiazepines, and tricyclic antidepressants are among the classes of medication commonly prescribed for psychoneurotic symptoms (Katz et al., 2007).

The role of medication in the treatment of psychoneurosis is a matter of ongoing debate. Some clinicians argue that medication addresses the biological basis of symptoms, while others contend that it merely suppresses symptom expression without addressing underlying causes (Chodoff, 2002). A balanced perspective recognizes that medication and psychotherapy may be complementary, with medication providing symptom relief that facilitates engagement with psychotherapy and psychotherapy addressing the underlying conflicts that predispose to symptom recurrence (Leichsenring et al., 2015).

6.3 Qualitative Aspects of Treatment Engagement

Qualitative research has illuminated aspects of treatment engagement that are relevant to psychoneurotic conditions (Qualitative systematic review, 2025). The therapeutic relationship, in particular, has been identified as a crucial factor in treatment success. Patients who feel heard, believed, and respected are more likely to engage actively in treatment and to achieve positive outcomes (Shedler, 2010). Conversely, patients who feel dismissed, doubted, or stigmatized may withdraw from treatment or experience worsened symptoms (Qualitative systematic review, 2025).

The issue of validation is particularly significant for individuals with psychoneurotic symptoms, whose suffering is often invisible or dismissed as "all in the head" (Kirmayer et al., 1994). The experience of being taken seriously, of having one's distress validated as real and deserving of attention, may be therapeutic in itself (Qualitative systematic review, 2025). This finding suggests that the quality of the therapeutic relationship, including the clinician's attitude and communication style, should be considered a central element of treatment.

7. The Future of Psychoneurotic Theory

7.1 Contemporary Psychoanalytic Developments

Psychoanalytic theory has evolved considerably since Freud's time, incorporating new understandings of development, psychopathology, and treatment. Contemporary psychoanalysts, while retaining the core concept of unconscious conflict, have broadened their focus to include attachment relationships, early trauma, and the influence of sociocultural factors (Eagle, 2011). The "modern psychoanalyst considers factors associated with later points of development when examining neurotic symptomatology" (Legorreta & Bronstein, 2024, p. 12): recognizing that psychoneurotic vulnerability may be shaped throughout the life course.

The concept of the psychoneuroses has also been refined in light of contemporary clinical experience. Some clinicians have identified links between psychoneurotic symptoms and "archaic problematics" that were previously associated primarily with borderline and psychotic conditions (Legorreta & Bronstein, 2024). This suggests that the boundary between psychoneurosis and more severe psychopathology is more permeable than traditionally assumed, and that psychodynamic treatment must be adapted to address the full spectrum of psychological suffering.

7.2 Neuroscience and Psychoneurosis

The relationship between neuroscience and psychodynamic theory is complex and contested. While some see neurobiological findings as undermining psychodynamic formulations, others argue that neuroscience can provide a foundation for psychodynamic concepts. Empirical research, such as that conducted by Howard Shevrin and colleagues, has provided "brain-based evidence for the presence of unconscious psychological conflict" (Shevrin et al., 1996, p. 84): suggesting that the concept of the unconscious has neurobiological correlates.

Advances in neuroscience may also illuminate the mechanisms through which psychological conflict is translated into physical symptoms. The understanding of brain circuits mediating emotion, stress response, and bodily perception may help to explain the complex mind-body interactions that characterize many psychoneurotic conditions (Damasio, 1994). This neurobiological perspective, while not replacing psychodynamic understanding, may complement it, providing a biological framework for the relationship between psychological experience and somatic expression.

7.3 The Psychoneurosis Concept in a Changing World

The psychoneurosis concept must be considered in the context of a rapidly changing world. The contributors to a recent volume on Freud's papers on neurosis and

psychosis have raised questions about "the way in which aspects of our rapidly changing world, social media, climate change, AI, influence the evolution of psychotic states" (Legorreta & Bronstein, 2024, p. xix). While their focus is on psychosis, similar questions may be asked about psychoneurotic states: how are these conditions shaped by contemporary social, technological, and environmental transformations?

The relationship between social context and psychoneurotic vulnerability is a theme that deserves further attention. The conditions of modern life, increased stress, social isolation, the erosion of traditional support systems, may create a fertile ground for psychoneurotic suffering (Horwitz & Wakefield, 2007). At the same time, changing cultural attitudes toward mental health may facilitate help-seeking and reduce the stigma associated with psychological treatment. The psychoneurosis concept, with its emphasis on the interaction between individual experience and social context, may offer a valuable framework for understanding these dynamics.

8. CONCLUSION

The psychoneuroses represent one of the most significant and enduring concepts in the history of mental health. Emerging in the late nineteenth century as a way of characterizing psychological disorders with no apparent organic basis, the concept was transformed by Freud into a framework for understanding the relationship between unconscious conflict, defence, and symptomatic expression. While the diagnostic revolution initiated by DSM-III dismantled the category of psychoneuroses, the concept retains clinical and theoretical value for understanding the complex, meaning-laden nature of human psychological suffering.

This qualitative exploration has traced the historical development of the psychoneurosis concept, examined its theoretical foundations, and analyzed the phenomenology of major subtypes. The paper has argued that the psychoneurotic framework offers resources that complement and extend purely descriptive approaches: a depth perspective that attends to the meaning of symptoms, an appreciation for the role of unconscious processes, and a recognition of the importance of relational context. While acknowledging the limitations and controversies associated with the concept, the paper has suggested that psychoneurotic understanding remains relevant for contemporary clinical practice and research.

The value of qualitative approaches in studying psychoneuroses has been emphasized throughout. By attending to lived experience, narrative coherence, and meaning-making processes, qualitative research can illuminate dimensions of psychoneurotic suffering that are not accessible through quantitative methods alone. The findings of recent qualitative studies, highlighting themes of "relationally regulated selves," the impact of stress and trauma, and the experience of being disbelieved, resonate deeply with the psychodynamic tradition and suggest avenues for future research.

The future of the psychoneurosis concept is likely to be shaped by ongoing developments in psychoanalytic theory, neuroscience, and qualitative research. The integration of these diverse perspectives may yield a more comprehensive understanding of psychoneurotic suffering, recognizing both its neurobiological underpinnings and its psychological meaning. In a changing world marked by new forms of stress and new opportunities for treatment, the psychoneurotic framework may offer enduring guidance for clinicians, researchers, and all those who seek to understand the depth and complexity of human psychological experience.

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